



DON'T FORCE REHAB HOSPITALS TO DENY PATIENTS CARE!



REQUIRE CMS TO STOP, STUDY AND MODERNIZE THE 75% RULE

BACKGROUND

To qualify as an inpatient rehabilitation facility (IRF) for Medicare payment purposes, a rehabilitation hospital or unit must satisfy, among other criteria, a test known as “the 75% Rule.” Under the 75% Rule, a facility must ensure that 75% of its inpatients are receiving treatment for one or more of 10 specified conditions. The initial list of conditions was based on an industry consensus document that represented the state of the art in the late 1970s. However, **the rule has not been updated since originally promulgated in 1984.**

As a result, newer rehabilitation specialties such as cardiac, pulmonary, pain and cancer are not reflected and therefore are not counted in determining compliance with the 75% Rule. IRFs have argued since the rule was implemented that the list of conditions should be expanded to reflect advances in rehabilitation medicine. However, **CMS has repeatedly failed to update the rule**, despite implementing an IRF prospective payment system (PPS) that pays facilities to treat a much broader scope of conditions.

In June 2002, CMS suspended enforcement of the 75% Rule out of concern that it was not being applied uniformly across the nation. On May 16, 2003, CMS published a proposed rule updating the IRF PPS for FY 2004. In the proposed rule, CMS announced its intent to lift the moratorium and enforce a narrow interpretation of the 75% Rule that, by its own estimate, only 13% of IRFs could satisfy. **The overwhelming message from almost 1000 providers and patients participating in a subsequent Town Hall Meeting and more than 6000 commenters on the proposed rule was to modernize the 75% Rule.**

In August 2003, CMS finalized the IRF PPS FY 2004 update without addressing the 75% Rule. On September 9, 2003, CMS published a proposed rule that would increase the number of conditions from 10 to 12 and temporarily lower the compliance threshold to 65% for a three-year period. **Unfortunately, we believe that the proposed changes, however well intentioned, will further limit patient access to inpatient rehabilitative care rather than improve it for those most in need.**

CONCERNS WITH THE PROPOSED RULE

- **While CMS expanded the number of conditions from 10 to 12, it did so by replacing one of the existing conditions – polyarthritis – with three new and exceptionally narrow conditions.** CMS acknowledges that the industry historically has understood joint replacement cases to fall within the definition of “polyarthritis,” and **admits that “these should be included in the conditions counted” under the current 75% Rule.** Sweeping aside two decades of practice, CMS now proposes to count joint replacement cases due to osteoarthritis only if the patient, among other things, has made no improvement after an “appropriate, aggressive and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings.”
- This means that, instead of being transferred directly from an acute care hospital to an IRF, many patients will need to seek care from an alternative site before becoming eligible for inpatient rehabilitation. **Patients who might have returned to function after a brief IRF stay would be required to undergo treatment in other settings in order to access IRF care. It would be a needless administrative burden for IRFs to verify the course of therapy received prior to an IRF admission.**
- **The requirement to undergo “aggressive and sustained” therapy in another setting before admission to an IRF is clinically inappropriate, lacks support in the medical literature, and is unmanageable. Patients assessed to be medically appropriate for IRF care should be sent directly to the right setting. In addition, CMS’ failure to define the “aggressive and sustained” standard would create confusion among providers and fiscal intermediaries.**

- **CMS also fails to define the phrase “aggressive and sustained” in relation to a course of therapy.** It is unclear how extensive a course of “less intensive” therapy must be to qualify as “aggressive.” In addition to trying to interpret these terms, hospitals and units will also bear the administrative burden of verifying the nature and extent of the therapy received by each patient prior to admission.
- **Moreover, in merely seeking to clarify one of the existing 10 conditions, the proposed rule does nothing to recognize the significant advances in medical rehabilitation since the 75% Rule was implemented in 1984.** Many changes have occurred in the past two decades, increasing the need for Medicare beneficiaries and others to have access to inpatient medical rehabilitation services. CMS’ own data analysis supports this by demonstrating an almost complete disconnect between the 75% Rule requirements and the conditions being treated by IRFs today. **We believe that any changes to the 75% Rule must reflect the strides taken within the field over the past 20 years.**
- **CMS’ effort to use comorbidities to verify compliance also does not increase the number of patients that get access to IRFs.** CMS proposes two alternative methodologies to permit patients with admitting conditions (including joint replacement) outside the list of 12 to be counted as falling within the 75% Rule if they have certain comorbid conditions. However, the proposed rule limits these comorbidities to the 12 listed conditions, and requires the comorbidity to be severe enough to independently require inpatient rehabilitation. Thus, **these patients would have already been included in the existing threshold by virtue of falling into one of the 12 categories.**
- CMS proposes to lower the threshold from 75% to 65% for a three-year period to give facilities time to come into compliance with the new criteria. While this is an improvement, **this temporary reduction – without truly expanding the list of qualifying conditions – will do little to mitigate harm to patients and providers.**
- **The proposed rule glosses over the negative impact that a dramatic shift from IRFs to other sites of rehabilitative care will have on patients overall by assuming that all such sites – from IRF to SNF to outpatient to home health -- are always equally available and effective.** IRFs provide a unique form of intensive care that is unduplicated by other settings with regard to the round-the-clock oversight of a physician, the hands-on role of rehab nurses, and the unmatched multi-disciplinary teams and coordination. **We are very concerned about the impact that this proposed policy change would have on patients, particularly the elderly and disabled served by Medicare.**
- Moreover, because compliance with the proposed rule would hinge on an IRF’s total patient population, not just its Medicare population, **CMS estimates that the proposed rule “may have an effect” on approximately 200,000 non-Medicare patients.** CMS does not quantify or describe this “effect” because it “does not have enough information.” However, we believe that the effect of the proposed rule is readily predictable: **facilities will be forced to turn away hundreds of thousands of patients suffering from non-listed conditions – both Medicare and non-Medicare – to avoid losing their IRF status.**

REQUESTED ACTION

CMS has had ample opportunity to expand and update the 75% Rule, and instead has proposed regulations that narrow the kinds of conditions that IRFs can treat. We believe that CMS should not implement the proposed rule or allow fiscal intermediaries to implement revised local medical review policies without further studying the likely impact on Medicare beneficiaries, non-Medicare patients, rehabilitation providers, and the Medicare program. In a July 7, 2003 letter to CMS Administrator Tom Scully, MedPAC Chair Glenn Hackbarth proposed that CMS lower the threshold to 50% for at least a year to enable an expert panel of clinicians to reach a consensus on the diagnoses to be included in the 75% Rule.

We urge Congress to enact legislation requiring CMS and its intermediaries to delay all regulatory actions, lower the compliance threshold to 50%, utilizing the industry’s commonly used interpretation of Polyarthrititis, and contract with the Institute of Medicine to study whether the current list of 10 conditions represents a clinically appropriate standard for defining IRF services and, if not, the appropriate clinical and medical standards applicable to inpatient medical rehabilitation facilities.